Sullivan County Department of Public Health

Title: Indwelling Catheter Insertion and Maintenance **Number**: CP- 21 **Page Number:** 1 of 3	Original Approval: 12/17 Reviewed/ revised: 5/24

Statement/ Purpose:
To provide guidance on indwelling catheter insertion and irrigation for females and males.

Authority:

Application:
All SCDPH CHHA RNs

Terminology:

Responsible Party:
Training and Quality Improvement Coordinator

Cross-Reference:
Hand Hygiene

Procedure:
Indwelling Catheter Insertion- Female
1. Confirm provider's order.
2. Explain the purpose and procedure to the patient. The purpose is to promote a controlled and patent urinary flow.
3. Prepare patient's room with light source and supplies.
4. Position the patient supine with knees flexed and spread wide.
5. Perform hand hygiene
6. Drape the patient to respect privacy and expose genitalia only.
7. Don non-sterile gloves.
8. Place moisture-resistant pad under patient's buttocks.
9. Wash perineal area with soap and water. Rinse and dry well.
10. Remove gloves and perform hand hygiene
11. Prepare a sterile field, opening all packaging of equipment in the catheter change kit and catheter packaging.
12. Don sterile gloves.
13. Apply water- soluble lubricating jelly to three inches of the catheter tip and place in the sterile field.
14. Insert syringe into balloon-channel, inflate balloon, assess for defects and deflate balloon.
15. Using non-dominant hand, separate labia. This hand is now considered nonsterile.
16. Clean urinary meatus from top to bottom.
    a. Use one premoistened swab to wipe one side. Discard.
    b. Use next premoistened swab to wipe the opposite side. Discard.

   c. Use third premoistened swab to wipe the center. Discard.
17. Pick up lubricated catheter with sterile hand.
18. Insert catheter into urinary meatus with deliberate but gentle motion.
19. When urine flows, use your non-dominant hand to hold the catheter in place.
20. Install sterile saline into the balloon. Refer to manufacturer's guidelines to identify the amount of saline required.
21. Connect catheter to tubing bag.
22. Pull back on catheter until resistance is felt.
23. Stop flow of urine after every 1000 cc for five to 10 minutes by clamping the tubing.
24. Secure catheter utilizing catheter securement device.
25. Dispose of supplies in patient's garbage.
26. Remove gloves and perform hand hygiene.
27. Instruct patient/ caregiver with catheter care guidelines.
28. Document procedure in the patient's clinical record, including:
    a. Color and amount of urine
    b. Patient's reaction to procedure
    c. Teaching/ instructions given to patient/ caregiver.

Indwelling Catheter Insertion- Male

1. Confirm provider's order.
2. Explain the purpose and procedure to the patient. The purpose is to promote a controlled and patent urinary flow.
3. Prepare patient's room with light source and supplies.
4. Position the patient supine with legs extended and slightly apart. Flex knees slightly.
5. Perform hand hygiene
6. Drape the patient to respect privacy and expose genitalia only.
7. Don non-sterile gloves.
8. Place moisture-resistant pad under patient's genitalia.
9. Wash perineal area with soap and water. Rinse and dry well.
10. Remove gloves and perform hand hygiene
11. Prepare a sterile field, opening all packaging of equipment in the catheter change kit and catheter packaging.
12. Don sterile gloves.
13. Apply water- soluble lubricating jelly to seven inches of the catheter tip and place in the sterile field.
14. Insert syringe into balloon-channel, inflate balloon, assess for defects and deflate balloon.
15. Grasp shaft of penis and hold it upright.
16. If patient is uncircumcised, retract foreskin.
17. Clean urinary meatus from top to bottom.
    a. Use one premoistened swab to wipe one side. Discard.
    b. Use next premoistened swab to wipe the opposite side. Discard.
    c. Use third premoistened swab to wipe the center. Discard.
18. Hold penis at a 45-degree angle.
19. Pick up lubricated catheter with sterile hand.
20. Insert catheter approximately six inches or until resistance is felt.
21. Hold penis perpendicular to the body.
22. Insert catheter up to Y. If resistance is felt, wait up to five minutes for meatus spasm to clear.
23. When urine flows, use your non-dominant hand to hold the catheter in place.
24. Install sterile saline into the balloon. Refer to manufacturer's guidelines to identify the amount of saline required.

25. Connect catheter to tubing bag.
26. Pull back on catheter until resistance is felt.
27. Stop flow of urine after every 1000 cc for five to 10 minutes by clamping the tubing.
28. Secure catheter utilizing catheter securement device.
29. Dispose of supplies in patient's garbage.
30. Remove gloves and perform hand hygiene.
31. Instruct patient/ caregiver with catheter care guidelines.
32. Document procedure in the patient's clinical record, including:
    a. Color and amount of urine
    b. Patient's reaction to procedure
    c. Teaching/ instructions given to patient/ caregiver.

Indwelling Catheter Irrigation

1. Confirm provider's order.
2. Explain the purpose and procedure to the patient. The purpose is to promote an unobstructed flow of urine through the catheter.
3. Perform hand hygiene.
4. Ensure patient's privacy.
5. Don non-sterile gloves.
6. Place moisture-resistant pad under patient's buttocks.
7. Open irrigation tray set.
8. Clean lip of irrigating solution bottle by pouring a small amount of premixed irrigating solution into the irrigation tray.
9. Clean juncture of indwelling catheter and catheter tube with an alcohol wipe.
10. Disconnect urinary catheter from drainage tube by twisting them in opposite directions and carefully pulling them apart.
11. Clamp the catheter.
12. Insert piston syringe tip into distal end of catheter.
13. Pour prescribed amount of premixed irrigation solution into piston syringe.
14. Unclamp catheter and instill premixed irrigating solution slowly using gravity.
15. If resistance is met, gently insert the plunger and apply slow, steady pressure.
16. If unable to irrigate, discontinue procedure and call provider.
17. Allow the irrigant to return to the tray while maintain sterile technique.
18. Wipe insertion tips of indwelling urinary catheter and drainage tube with alcohol pad.
19. Reattached indwelling urinary catheter to drainage tube.
20. Discard solid waste into patient's household trash. Dispose of irrigating solution in patient's toilet.
21. Remove gloves and perform hand hygiene.
22. Document the procedure, including the following in the patient's clinical record:
    a. Condition of surrounding skin
    b. Irrigant type and amount
    c. Colo and amount of return
    d. Patient's reaction to the procedure.